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Regulatory and Tax Developments Affecting Life Product Development

Track: Product Development

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Summary: Changes to reserving and tax regulations affect the products that the life insurance industry develops and sells. Our panel discusses recent developments in statutory reserving and tax regulations. Attendees learn about recent or proposed developments in statutory valuation and tax law and the implications they have on product development.

MR. VRATISLAV VODRAZKA: Actuarial Guideline XYZ (AG XYZ) began when secondary guarantees started materializing on many universal life (UL) and variable universal life (VUL) products. These secondary guarantees lasted for long terms—such as 30 years, 40 years, or for the lifetime of the policy. With a secondary guarantee, there is a minimum premium, and as long as this minimum premium is paid over a specified term, there is a guarantee that the UL policy will not lapse, regardless of what's happening to the minimum surrender value.

This is similar to whole-life policies or term products, but because of the way this is set up, no cash values are being developed. And so some people said that it was unfair that UL and variable VUL have this advantage.

AG XYZ is trying to fix the way the longer-term secondary guarantees develop cash values by providing an additional calculation. This guideline is supposed to apply

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only to UL policies with secondary guarantees longer than 20 years. So, if your secondary guarantees on your UL products are 20 years or less, you can breathe a sigh of relief.

There are people on both sides of the fence debating whether or not AG XYZ is a good idea. The committee is trying to make the guideline optional, so that states that support the guideline have the option to adopt AG XYZ and states that oppose it are not required to adopt AG XYZ. The committee will be meeting in Pennsylvania soon, where it will try to push for AG XYZ to be turned into a regulation. Because adoption of the guideline is intended to be optional, it would be very difficult for companies to be able to determine whether or not a state had adopted AG XYZ. I call it an actuarial "guideline" rather than a "regulation," because it has yet to be made official, but that's the route the committee may be taking.

Currently, many companies use a retrospective calculation for secondary guarantees to determine whether or not there are any cash values. This procedure accumulates minimum premiums and deducts charges using the maximum guaranteed costs of insurance (COIs). It's almost certain that, in any case, applying that calculation, you're not going to develop any cash values. AG XYZ equates the mortality with the premiums that are being used to calculate the minimum surrender value under the secondary guarantees.

AG XYZ calculates value "R," which is a multiple of the guaranteed COIs, and equates the present value of premiums to the present-value death benefits, plus present-value other benefits (which may include maturity benefits or bonuses) plus present-value allowances. AG XYZ uses the minimum specified interest rate, or 4 percent, for products that do not specify the minimum interest rates.

There are two types of expense allowances being used. One is the administrative cost, which is the minimum of the administration cost scheduled at issue or $120. There is also a premium-based allowance, which, for the first year is 125 percent of the level premium, plus $10 per thousand, or $60 per thousand if lower. For renewal durations, the cost is 20 percent of the level premium. Some policies out there have a minimum premium that varies by duration, so there is a formula to try to equate it to a level premium, and that's what's used in this calculation.

Once we have our modified mortality rates, we can use the retrospective approach, which accumulates premiums and deducts withdrawals, expense allowances and the COIs, which are based on the modified mortality rates. You can accumulate values using either actual credited rates or the interest rate used to calculate "R." The rate you're going to be using has to be specified at the beginning. For most companies, the main objective is to try to minimize the minimum surrender values.

In this calculation, there is the minimum surrender value that is calculated for the secondary guarantee; then there is the regular minimum surrender value that accumulates premiums at the credited rate and whatever charges are on the policy.

For the final minimum surrender value, take the greater of the two.
What is the value to the consumer? There is an investment component in that there may be higher cash values and surrender values, especially for the longer secondary guarantees. For example, if a company lets me buy an insurance policy with the intent to surrender the policy 30 years from now, it might come out with a higher value than it would otherwise, as a result of this guideline. And the people who will persist are typically those who will bear the brunt of that, possibly through higher charges.

What are the system implications for companies? The formulas seem pretty straightforward and are not that difficult. But when you try to modify some administration systems, it can be a real hassle. I don't know if any of you have tried to dig into administration systems, but sometimes they're not quite as user-friendly as they could be. Trying to find the perfect spot to put your calculations, without impacting any other calculations in the software, is a very difficult task and requires hours of testing once it's done.

Obviously, you need to find the programmer time as well as the resources that are going to be used in testing the software once all this is done. And that's going to require finding people who can allocate the time to this project. It is probably going to be an arduous project, requiring the assistance of consultants, which means that it's not going to be inexpensive.

Illustration software will have to be modified as well. Or, if companies decide that they do not want the long-term secondary guarantees, they're going to have to re-file their products, which will require resources that could be better utilized elsewhere.

What is the industry sentiment to AG XYZ? There are people on different sides of the fence. Life insurance companies with the long-term secondary guarantees obviously are going to be strongly opposed to the guideline, because of the high expenses involved in making the changes to their systems or in having to re-file their products, because they're going to have to remove the secondary guarantees.

Companies that preferred to have shorter-term secondary guarantees are probably thinking that this is going to put them on a more level footing with other companies.

Many regulators don't think AG XYZ is necessary. We've been operating without it for a long time. There have been long-term secondary guarantees, and consumers haven't been complaining that they're not getting sufficient surrender values. So, I believe there are regulators on the side of many life insurance companies in viewing this as an unnecessary hassle.

This raises the issue of optional AG XYZ adoption. Well, if it's optional, that means maybe only a few states will adopt it. A big state, such as Florida, might adopt it,

and Florida is not insignificant. If you're going to do business in Florida, and you want the long-term secondary guarantees, you're going to have to change your systems, regardless of whether it's adopted by 10 or 50 states. A partial solution might be to sell a short-term guarantee in the states that do adopt and keep the long-term guarantees in the states that don't.

Offshore Reinsurance. Why go offshore? What are some common locations that reinsurers use? What are some common offshore structures? Can companies that want their own offshore benefits without necessarily having to utilize reinsurance do that as well?

Why go offshore? Offshore companies are not subject to U.S. insurance regulations and income taxation levels, depending on whether or not the company is set up as a U.S. taxpayer. If the company is set up as a non-U.S. taxpayer, then there are usually lower income tax rates. But there's also the potential for excise taxes, which can more than offset the gains that can be achieved through the lower income tax rates.

Often there are lower capital requirements. A lot of countries utilize economic accounting methodologies that are similar to U.S. GAAP, permitting more realistic assumptions than onshore statutory reserves. Typically, the reserves end up being considerably lower—especially with Regulation XXX, which had a tremendous impact on the reserve levels that companies had to hold on long-term products. Many companies have turned to offshore reinsurance, so that the offshore reinsurer can better manage the capital in these countries that have more favorable accounting methodologies.

Another advantage is that the common offshore locations typically have more aggressive and flexible investments that companies can undertake, which can potentially gain higher investment returns.

And, of course, there are palm trees and great beaches as an added incentive. Although, realistically, it's not all fun and games to have to be the first to start a company offshore. When a company is set up as a non-U.S. taxpayer, it has to have people actually making decisions in that country. And some of those people will find that relocating to a foreign land is not always a great situation. Some of these countries can be very expensive. It can be very difficult for some people to find available space in school for children. A place like Bermuda, typically, has a two-year work visa. After two years, people basically are forced to go back home to whatever jobs they had previously.

There are some common locations for offshore reinsurance companies. Bermuda continues to be, by far, the most popular. There's also the Cayman Islands and Barbados in the Caribbean. I've been told that, at one time, Luxembourg was very popular in Europe. And I believe Dublin, Ireland, is very popular right now. South America was once utilized for domiciling offshore reinsurance companies, but

currently that is not the case because of its unstable economic environment. Offshore reinsurance companies, when selecting a place of domicile, must be careful about the country's currency. If you have an unstable economic environment, the currency may fluctuate. If you haven't hedged your currency properly, you're going to run into some potential problems. Or, if you have hedged it in companies with unstable economic environments, then you have to pay a lot for your hedges.

I'm going to review some decision components of existing as a U.S. taxpayer or not. If you set up your company as a non-U.S. taxpayer, you potentially reap the advantage of the lower income tax rate available in certain countries. Again, consider that different products have different excise taxes, so the excise tax might wipe away all gains from the lower income tax rate.

An offshore company is not admitted as a reinsurer in the United States, meaning that it is not authorized or licensed in the United States as a reinsurer. That means that you cannot offer reserve credit in the traditional sense that U.S. reinsurers do.

There are stricter requirements for non-U.S. taxpayers in soliciting business. Typically, companies are not allowed to do a lot of business on U.S. soil, in terms of soliciting business, if they're non-U.S. taxpayers. The IRS could impose U.S. taxes if it's determined that the company is actually not following those rules and is soliciting a significant amount of business on U.S. soil.

Since offshore reinsurance companies are not considered admitted reinsurers, they have to be able to provide reserve credit to ceding companies through some fashion. Some popular methods are through funds withheld, setting up trusts, and letters of credit. Right now, the most popular option is the letter of credit, and that's the one I'll focus on.

To meet statutory requirements, a letter of credit must meet certain criteria. It must be clean, meaning it allows the ceding company to draw upon the funds at any time for the full amount of the letter of credit, simply by presenting a demand for payment. Additionally, it must be unconditional and irrevocable. This means that the letter of credit is not subject to any conditions or qualifications outside of the letter of credit itself, and cannot be modified without the consent of all parties.

The letter of credit must have a term of at least one year with an "evergreen clause." The evergreen clause provides for automatic renewal and at least 30 days notice prior to cancellation. The letter of credit must be issued by a bank that is regulated in the United States and has been approved by the Securities Evaluation Office of the NAIC.

When the reinsurance company has secured the letter of credit, the ceding company has in front of itself a highly liquid asset that can be turned into cash at any time. If the ceding company feels that the ongoing viability of the reinsurer is

in question, then the full amount of the letter of credit should be drawn upon. Since, ultimately, the bank may have to honor the promise to pay, the NAIC regulation provides added protection by requiring that the bank backing the letter of credit be an acceptable U.S. regulated financial institution. The bank's obligation to pay is not contingent upon the ability to recover the amounts drawn.

If you're still interested, how do you set up your own offshore company? You can set up an offshore captive or you can use a reinsurance cell. If you set up a captive reinsurer, you have to choose the right country and, to do that, you have to understand the complexities of the different countries. I already explained some of the things that you have to look for when trying to select the right country.

You have to capitalize the company, of course. Then there is also an affiliate-reinsurer risk, which basically says that, if the IRS determines that the pure purpose of setting up the reinsurance company is to try to avoid U.S. taxes, then the United States can impose those taxes on the company.

As I mentioned, there is also a reinsurance cell, which is a protective cell that a reinsurance company can set up on behalf of another company within the reinsurer's offshore company. By doing this, the profits and losses of a cell are segregated from the reinsurer's other business. The direct company uses its own capital to capitalize the cell. This is a lower-cost alternative to setting up your own offshore captive, and you still get to utilize the favorable accounting methodologies available offshore.

There are some things that companies should look for when selecting offshore partners. The offshore reinsurance company should have solid experience and understand unique considerations and ongoing administration. You must believe the reinsurer can fulfill the terms of the agreement. You know that term products have humpback reserves. Right now, we're within the early stages of Regulation XXX, so a lot of the reserves that are being set up are very small. The company should make certain that the reinsurance company they're partnering with is a well-capitalized company—a company that is going to be around a long time—because once those humpback reserves kick in, companies may not have the capacity for setting up a letter of credit or other forms of reserve credit.

Another thing to look at is the jurisdiction of the offshore entity. Just make sure that the country where the offshore reinsurance company is set up has a stable economic environment and will be able to provide the reserved credit that the direct ceding company is relying on.

MR. DOUGLAS ROBBINS: We're now going to move on to some tax considerations. Craig Pichette is going to help us out. Craig works in the insurance tax practice of KPMG. He is a federal tax partner with 15 years of experience working on company and policyholder tax issues, including mergers and acquisitions, life or non-life planning, IRS exams, cross-border insurance and

reinsurance transactions. He's going to cover the estate tax and split-dollar arrangements. I think he has a bonus issue for us on mergers and acquisitions (M&As) as well.

MR. CRAIG PICHETTE: I'm going to spend a little time getting off-topic on recent regulations that the IRS has put out that are important. Most of us have so many different responsibilities that we should probably spend a little time on it. The IRS put out some regulations a couple of months ago now. I was on the phone with one of my colleagues, and he described them as monumental. Then he thought about it for a couple of minutes and said, "Well maybe not monumental, but probably the most important thing to happen in insurance tax for the last 10 years or so." It's really an M&A issue. I'll spend a few minutes on some of the basics.

Companies have a lot of flexibility when they acquire a target—whether a target asset or legal entities—for a whole bunch of regulatory reasons that most of you probably are pretty familiar with. A 338(h)(10) election is a provision in the codes that allows buyers to acquire target stock from sellers but treat it, for tax purposes, as an asset acquisition. And it's a joint election made by those parties. There are deemed steps in the transaction where the target is first deemed to liquidate its parent and then the parent is deemed to contribute all the target assets back down to a new target; then the new target sells those assets to the buyer.

The motivation between the buyer and the seller is that the buyer wants to get a basis step up for target assets. If you buy stock for accounting purposes, if you buy target stock, you do purchase accounting, push down the purchase price and step up the basis with all the assets. For tax purposes, if you buy target stock, you don't do that. You just get a big outside basis and the target's inside basis stays low in its assets, because you don't push down accounting on a stock acquisition. And so you then create this excess of purchase price over your tax basis in the assets, which potentially generates future taxable income for the buyer.

So, 338(h)(10) allows the acquirer to buy target and step up the basis of the assets, but still do a stock acquisition. The way an (h)(10) election works is that the buyer and the seller take the purchase price, plus the liabilities assumed, and calculate something called the adjusted grossed-up basis or adjusted deemed sales price for the seller. That purchase price then gets allocated out, under these ordering rules, to various types of assets—most of which, for an insurance company, obviously, goes into Class II and III assets for the investment portfolio. There are also assets that go down into Class VI and VII intangibles.

Table 1

Section 338(h)(10) - Background

Purchase Price
\+ Liabilities Assumed
= Adjusted Grossed-up Basis
Allocated to
Class I Assets – Cash
Class II Assets – US Government Bonds
Class III Assets – Marketable Securities and Receivables
Class IV Assets – Inventory
Class V Assets – All other
Class VI Assets – 197 Intangibles
Class VII Assets - Goodwill

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The seller, likewise, allocates the purchase price out under the same methodology, for the purpose of determining how much gain or loss it has in the sale of each specific asset. A lot of the issues come down to how you allocate the purchase price between each of those categories of assets, particularly when you get down to the Class VI and VII assets, which matter a lot to both the buyer and the seller.

When making an (h)(10) election, there are seller and buyer considerations that get resolved during the negotiations that are pretty important to both parties. From a seller's perspective, there are character issues. And whether they are sales, or capital gains, or ordinary income, the big issue for some sellers who have expiring capital losses is, if they sell stock, they have obviously owned capital-gains losses. If they sell individual assets in an (h)(10), the character of the gain or loss depends on each of the underlying assets. And there is a deemed reinsurance transaction as part of this, and the ceding commission income is ordinary to the seller, so you can have a character difference between selling stock and making (h)(10).

The amount of the gain or loss can differ for the seller. It has its basis and it stock at the target. And the target has inside basis of its assets, which will quite often be different for a whole bunch of reasons, historically relating to how the target was acquired by the seller and its ability to file consolidated returns over the period of time that it has done them.

And finally, from the seller's perspective, if it sells stock, there's a series of tax rules out there that limit the ability to recognize that loss. There is a series of U.S.

Department of Treasury regulations that was recently struck down by the Supreme Court, basically saying that you can't take the capital loss on the sale of stock at a subsidiary. The IRS is in the process of replacing those rules with some new rules that may limit losses in similar situations. There are no limitations on the ability to recognize losses on sales of assets, so if the seller was in a loss-limitation situation, it often wanted an (h)(10) election.

The buyer's principal considerations relate to the ability to obtain deductions for the value of the business they've acquired. And the principal feeling about purchased GAAP accounting is you end up with a large amount of purchase price allocated to the value of the in-force. And the same thing applies for tax purposes. If you're going to assign that value to an intangible asset, by making an (h)(10), you can get a deduction for that over 10 or 15 years.

There's been a lot of controversy over the tax treatment of (h)(10) elections for insurance companies over the past decade or so, which is why these regulations were finally issued. And there have been discussions with the IRS and Treasury Department for about seven or eight years regarding some of these issues. It took them a long time to issue these regulations. But the main driver was the need for certainty in pricing transactions. A lot of time gets spent on purchase and sales transactions between the buyer and seller—trying to decide if they should make an (h)(10) election or not—because often the motivations of the two parties are very different and the benefit ends up getting split up between the parties somehow. There is need for certainty around these issues, so that the buyers and sellers can effectively price these transactions.

Much of the need for this comes from the IRS position that, in an (h)(10) transaction, an asset purchase involves a deemed assumption reinsurance transaction. Its theory is that the only way you can transfer an insurance business is through an assumption reinsurance transaction, so they impute one into the stock transaction as part of the (h)(10) election, and that affects the character and timing of income and deductions to buyer and seller. And there are a variety of issues around how you compute, carve out, if you will, from the overall deemed reinsurance transaction.

Since the IRS imposed this assumption-reinsurance accounting regime on these acquisitions, you could find yourself in a situation in which you run into some regulations that have been out there for a long time, under pre-1984 law or section 817, that basically said, if your purchase price plus the liabilities assumed were less than the value of the assets you acquired, you added income to the buyer. That's what would happen to the negative ceding commission in an assumption reinsurance transaction with those facts. And, it could happen in a 338(h)(10) situation as well, so there was this significant issue about how you can have income when you buy an asset. And there are many tax case laws out there that say that, if you make a bargain purchase, you cut a good deal and just step down the basis of your assets. You, therefore, don't have income and negative ceding commission.

But there are these regulations under 817 that said that you could have a negative ceding commission with income. There was a lot of discussion in the IRS about whether those regulations were appropriate at all, even in an assumption reinsurance transaction, and whether they should be applied to the purchase of the trade of business in an (h)(10) election.

And finally, there were some questions about what happens to the historic policyholder surplus account (PSA) in the 338(h)(10). The PSA account dates back to a pre-1980, 1959 act, when life insurance companies were able to defer the tax on some of their income. That income was allocated to this PSA account, and ultimately it could be taxed when distributed. If there was a deemed distribution of the PSA as part of this 338(h)(10) election, then you'd have tax on income that nobody ever expected to pay tax on. Nobody ever expects the PSA accounts to be triggered into income, as the IRS asserted on auditing, and, for some taxpayers, the PSA accounts were distributed in certain back patterns. So there was some need for clarification on that issue.

The federal regulations were released in early March. They'll be effective on the date they're issued in final form. They're fairly workable rules overall and a good indication of what the IRS's thoughts are. So people are looking at them carefully as they do transactions.

The IRS issued regulations under three different provisions: 338, which contains the rules relating to the 338(h)(10) acquisitions; 197 which provides rules for amortizing acquired intangibles; and section 1060, which deals with asset acquisitions that aren't 338(h)(10) elections. In other words, if you do a straight asset acquisition or assumption reinsurance transaction, there are issues about whether you apply assumption-reinsurance accounting models or this 1060 asset-acquisition accounting model.

Basically, they're designed to bring some level of consistency to tax treatment of asset acquisition and reinsurance transactions, where in the past we had different accounting rules. The ACLI had a meeting in Washington a couple of weeks ago, where a variety of people from the industry got together and shared some of their thoughts. And they're now compiling comments to be submitted. I think, in general the response has been favorable to the regulations. There are a few problems that people have, but most of the comments that will be submitted will clarify unclear issues.

Basically, the regulations end up saying that the ceding commission on deemed assumption reinsurance transactions is equal to the fair market value of the contracts acquired. So you have to do a valuation of the insurance business. Many of the deals that I've been involved in have a lot of valuations floating around, and I think there is some question as to what is the right fair market value for the business. If you value the business at $1 billion dollars and the seller wants a $1.5 billion, and the buyer offers $800,000, and you settle at $1.1 billion or something,

what's really a fair market value?

That provision also deals with the bargain-purchase problem, where the IRS set the amount of the premium equal to the tax reserves for the contracts, so that, just through the mechanics, it eliminates the bargain-purchase problem—even though it generally says you're going to follow the reinsurance accounting model in the 817 regulations.

Another important point is that life reserves are not contingent liabilities. Contingent liabilities are a problem. There a is case law that says, if a liability is contingent at the purchase date, and the buyer later increases the liability and gets it—where they would otherwise get a deduction if it's an acquired liability and it's contingent—then it's a purchase-price adjustment. Nobody gets a deduction for it, essentially. Let's clarify that life reserves generally are not contingent liabilities. So if you have to strengthen reserves or change reserves for some reason after a 338(h)(10), this should be deductible to the acquirer.

There are also issues regarding tax deferred acquisition cost (DAC), which is the amount of a premium you have to capitalize when you issue business or do a reinsurance transaction. In most of them, the seller has a large negative deemed premium on the transaction. It provides a general rule that it's deductible to the seller if the seller has a net negative DAC after the transaction. It carries up to the parent in the deemed liquidation, if the parent is an insurance company. If the parent isn't an insurance company, the negative DAC just disappears. I think there's going to be some comment that that's not an appropriate rule, and that there should be a net deduction for the negative DAC. Because the assuming company is picking up a positive, and one of the principles underlying all the DAC rules is that the books of the world should balance, you should have a positive and a negative on both sides. This regulation leaves a positive to the assuming company and a negative to the ceding company.

Finally, on the PSA issue, if the seller is a nonlife company, and the PSA is triggered, the amount of the distribution is the purchase price, because, as I said, you have a PSA distribution only to the extent that there *is* a distribution. So, if the PSA is greater than the purchase price, any balances were forgiven, which was a good rule; but I think everybody has thought for a while that, if the selling parent was a nonlife company, the PSA was probably triggered.

If the seller is a life company, the seller inherits the PSA. I think everybody thinks that is the right answer. But the IRS came up with this sort of bizarre rule that says the seller has to acquire more than 50 percent of the target's insurance reserves, and there is a theory that the PSA follows the business.

That ignores the fact that all the business that the PSA relates to probably ran off everybody's books 20 years ago, and it's just a pretty irrational theory on their part. I think there will be a lot of comments contesting that.

The 1060 transaction rules generally follow the (h)(10) rules in terms of purchase-price allocations in asset acquisitions, or they just apply to straight asset acquisitions. And the issue has always been that a reinsurance transaction is an asset acquisition. Therefore, which rules apply, the 817 reinsurance accounting rules or the 1060 rule? If, in the reinsurance transaction, the purchaser acquires significant business assets beyond just the insurance business—systems and employees and those kinds of things—then it's a 1060 transaction rather than a reinsurance transaction, and the (h)(10) rules we just went through will apply, rather than the reinsurance accounting rules.

In general, the response to those regulations has been favorable. There are some issues regarding the PSA and other things, but it'll lend certainty to buyers and sellers in some of these transactions and help some of the pricing issues that people have been running into.

My second topic is the split dollar. There have been a couple of notices the IRS has put out in the last couple of years, namely 2001-10 and 2002-8, dealing with split-dollar issues.

There is a wide variety of different types of split-dollar arrangements, all of which involve the employer and the employee paying some amount of the premium. But the employee generally gets the investment return in the contract, if you will, and the employer gets a return of the absolute value of the premiums. Generally, they have set up deferred compensation arrangements for executives to facilitate estate-planning needs or purchase the sale arrangements that are needed for small- and medium-sized businesses.

There are two types of arrangements, generally, depending on who owns the policies—collateral assignment arrangements, where the employee owns the policy; and endorsement arrangements, where the employer owns the policy and the employee names the beneficiary of the policy.

The tax characterization of these two different types of split-dollar arrangements is very different under the IRS rules, and it's an important distinction.

There have been two characterizations of these arrangements that the IRS has tried to impose on taxpayers over the years. To summarize the issues, they can be characterized as a series. The premium payments by the employer can be characterized as a loan to the employee. Alternatively, the value of the insurance protection provided, plus the investment buildup, could be deemed to be income to the employee.

Other issues concern the amount of employee income for the insurance protection provided, which has usually been expressed in terms of current term protection. And there have been issues about what tables or rates should be used to value those benefits. There was prior guidance over the years, mainly back in the '60s, in

the form of IRS rulings that dealt with earlier forms of split-dollar, and you really didn't deal with the kind of split-dollar arrangements that are being marketed currently.

Prior to notice 2001-10, both types of arrangements were treated identically. They were generally not treated as a loan. PS 58 rates were current published-premium rates, used to determine the value of the term insurance provided to the employee. And there were concerns regarding how much, and when, you taxed the value of the cash-value buildup that was going, ultimately, to the benefit of the employee.

The final point is really the big issue that the IRS is trying to address in some of these notices.

The IRS put out 2001-10 in early 2001 because it thought the marketplace had been moved past the guidance published in the '60s. The IRS thought that the PS 58 rate understated the benefits to the employees and, in other cases, overstated the benefits. It essentially thought that the PS 58 rates weren't appropriately valued. In addition, most companies, I understand, use the provision that said you could use the term rates that you're currently providing in the market. The rates the companies were using for this purpose *were not* what they were actually offering in the market.

In the notice, the IRS essentially said that section 83 deals with the deferred compensation applied to these contracts, in that it would apply to the time that beneficial interests in the cash value transferred, although it wasn't clear as to when they thought that happened. The issue essentially comes down to when the employer, at some future date, pulls its premiums out. Because he or she now has all the economic ownership of the policy, is the employee taxable at that time? That wouldn't apply when the employee was the owner of the contract from the initial date—so, in the collateral-assignment kind of arrangement, that wouldn't apply. To those arrangements, though, they said section 7872, which is a series of deemed loans, may apply. And the IRS essentially replaced the PS 58 rates with what they called Table 2001 rates, which most people thought were an appropriate measure of the value of insurance provided.

In 2001-10, the IRS essentially said they would accept the party's characterization of the arrangements as insurance or loan if it consistently followed it, and if all the economic factors were accounted for.

The IRS left the choice up to companies and policyholders. They said the parties could elect loan treatment, and 7872 would apply to employer payments, so that, as the employer made premium payments that were a deemed loans to the employee, there would be imputed interest and compensation issues associated with that.

The employee, in that case, doesn't have compensation income, because it's a loan

instead of compensation. And there wouldn't be a transfer of cash value, subject to section 83.

Alternatively, in an insurance treatment model, the employee has compensation equal to the value of the term insurance provided on amounts distributed to them from the contract. And there are issues as to whether the ordering rules are on income first or recovery of basis first. On the cash value, the issue comes down to, when is the interest substantially vested? Is it when I think the term rollout occurs and the employer pulls out the premium, or at some other date?

The IRS issued a new Table 2001 rates to replace PS 58 rates derived from group term-life tables. They said you could use your actual rates through 2003, provided they are actually available.

I think the insurers reacted pretty negatively to 2001-10. There were a whole bunch of issues that the industry just wasn't comfortable with. And there was a lot of discussion in the Treasury Department over the course of last year, dealing with some of these issues. So they put out 2002-8 this year, revoking 2001-10, saying at some future date, the Treasury would issue regulations on these issues.

Basically, they said the regulations, when issued, will provide that insurance characterization will imply the employer is the owner of the policy, and it will be treated as a loan. If the employee is the owner of the policy, it brings some certainty as to how you treat each arrangement.

As we said before, if the employer is the owner of the policy, it'll be treated as insurance and there are some compensation issues. There's no income solely based on increases in cash value, but there are still issues as to when you recognize that as income. And then the loan treatment applies if the employee is the owner of the policy.

As to term rates, the IRS said PS 58 rates can be used for contracts issued before the notice was issued. For arrangements entered into before the final regulations, you have to use 2001 rates. Or you can use actual current rates, prior to the issuing of final regulations, inferring, I think, that when they issue final regulations, you're not going to have that option anymore.

In general, I think the IRS perceives split dollar to be an abuse, if you will, for whatever reason, and they want to restrict its use. I think the industry has some problems with that, and we'll see how this rolls out over the next several years. I wouldn't expect the regulations any time soon. The IRS is generally slow in getting regulations out.

Finally, estate tax, as you know, is being phased out through 2010. The exemption amount is increasing, and the rates are dropping. You eventually will reach the point where there is no estate tax. The problem is that these are temporary rules;

in 2011 everything reverts back to the laws as they are now. I don't think anybody believes that this is sustainable, but there just isn't a real consensus as to what's really going to happen, or what the right rules should be. You know, it's a pretty hot topic. Why aren't we taxing these billionaires? And there's a lot of political uncertainty, I think, as to where this is going, which makes it very difficult for both policyholders and companies to try to plan around it.

If you have a lot of money, I suppose you hope it's permanently extended. If you're trying to sell estate-planning tools, it's probably not such a great provision. But, you know, if you have a different president in office and a different party control in Congress, you can get very different rules than what are currently out there.

Just a couple of other points I want to mention. Net corrections to 2001-42 were issued last year, replacing the existing guidance on correcting failed modified endowment contracts. Largely they're just a series of mechanical rules, I think. At least my experiences with the IRS have been pretty positive. It's a pretty mechanical process. There are not a lot of issues. The main issue that I run into, frankly, is that some companies don't have taxpayer identification numbers for the insureds, and the IRS is insisting on those—even though there is really no underlying policy objective served by that. So we've had to pull some individuals out of those submissions and tell them that they have to deal with those issues.

There's also one other thing I just wanted to touch on. There has been a lot in the press lately about corporate tax shelters. The IRS's record on those is somewhat spotty. It tends to win in Tax Court and lose in the Court of Appeals. Can reserve planning be considered a tax shelter? Since the IRS almost literally defines a tax shelter as anything that reduces anybody's tax liability, any planning to increase tax reserve will probably be interpreted as a corporate tax shelter, and might be subject to all the reporting regimes and everything else set out in some of the regulations.

Ultimately, you probably win if it is good planning. But you might get tainted, if you will, by doing a corporate tax shelter. I think that, since the IRS is losing so much in court on a lot of these deals, they'll probably go for some kind of legislative fix. That will probably cause more problems than it will solve.

That's enough data on some of the things that happened that affected our industry over the last year.

MR. ROBBINS: Well, we've had a couple of presentations covering regulatory and tax issues that apply directly to how we, in many cases, value or set up cash values for policies, how we plan taxes and how we develop products.

I'm going to tackle Actuarial Guideline AXXX (AG AXXX) and Actuarial Guideline 37 (AG 37). And if I have a little time at the end, I'm also going to cover some of the implications of the new 2001 CSO table.

I am a consulting actuary for Tillinghast-Towers Perrin. I've been doing this since 1995, and I've worked extensively in product development. In fact, I guess it would be considered my specialty.

Some regulators on AG AXXX and AG 37 have been looking at the way things are going, and they can see that it's not working the way it was intended to. And that is causing some problems in creating an even playing field, particularly with AG AXXX, which is in the exposure/proposed stage. We're going to talk about what's happened with fund-driven products on the fixed side, and a little bit about term as well.

I'll cover the basics of flexible fund-driven products. For those of you who may not be familiar with these, on a flexible product like UL, the base plan of insurance doesn't necessarily mature. The policyholder can alter the way he pays premium, and the company can change the charges or the credited rate, subject to some constraints. If the fund runs out, the insurance typically does too, or you can have it mature for more than the face value.

Because the policy is so flexible, the reserve methodology must be flexible. You can't just have a set of factors that start at duration zero and run to maturity. The valuation methodology laid out in the UL model regulation starts with a calculation of guaranteed maturity premium. In other words, if the company credited the minimum and charged the maximum, what premium would still guarantee that you come to $100,000 at the end, if $100,000 is the face value?

That allows you to calculate a guaranteed maturity fund that runs from duration zero through maturity, and then that fund is the basis for a guaranteed-basis whole-life plan of insurance. You can use something like reserve factors, based on that, but those factors are adjusted somewhat, depending on whether the actual fund is on track or not. The actuals could be bigger or smaller than the factor reserve.

Why am I covering that old ground? First, as a basis for contrast. We're going to talk a lot about fixed no-lapse guarantees, and I'm going to be using some of the terminology from flexible reserving to discuss that. And secondly, as a reminder of how we treat flexible features, because some of the stuff that we're going to talk about for AXXX is, in fact, flexible at the end of the day.

So here we are: Regulation XXX, AG AXXX and UL. Most of you are familiar by now with Regulation XXX. It applies in one sense to term and another to UL. For term, you do a test, based on the mortality rates and the premiums, to determine where your segments come out. For UL, on the other hand, a no-lapse guarantee that's based on a set of fixed premiums, regardless of what happens once that period ends, is considered a segment.

Nonguaranteed premium patterns, of course, are irrelevant. If an agent sells a

policy saying, "You could pay this level premium amount and you might get insurance for that period, but you might not"—that's not covered under XXX. Nobody really argues with that. So the $64,000 question—and maybe in this day and age, I should say $1-million question—is, what constitutes a guarantee in the UL sense, or a nonguarantee?

The first answer: A set of level current premiums that is illustrated but not guaranteed by the agent is not guaranteed and, therefore, does not become a XXX consideration. No one really disagrees with that. Well, if Regis were here, he might say, "Is that your final answer?" And I'd say, "No, otherwise, my session would be done already."

Is there a way to guarantee a no-lapse period without really guaranteeing it? In other words, is there a way to tell the policyholder that he or she has a guarantee when you're really holding something back?

Actually, right after the start date for XXX, many companies seemed to think so. There are four perceived loopholes that were used a bit for UL and a lot for term:

- First, by guaranteeing that, if loads were ever raised, or if premiums were ever raised, and that caused the policy to lapse, a refund or a bonus would occur.

- Second, by guaranteeing loads will not be raised during the level period, unless some specified event occurs. And that event is usually something very unlikely, like the Moody's corporate rate drops below 3 percent, or something like that.

- Third, one can have a guaranteed dividend scale, or guaranteed refund schedule, that nets out with your guaranteed premiums, to a low-net guaranteed cash flow, or guaranteed premium.

- Fourth, one can have a guarantee issued by a second affiliated company or a reinsurer, either of which might not have to hold XXX reserves on the part that they're taking from you.

Since the initial premium level is not guaranteed, or isn't fully guaranteed, these were perceived as possible loopholes.

Well, the exposure guideline AXXX deals rather harshly with all these ideas. And it does it immediately. The first three ideas were nixed outright. In the case of the 3 percent Moody's thing, you can't control what the Moody's rate does, therefore that's a guarantee. It doesn't matter that you have an out in some very minor percentage of future interest rate scenarios. It doesn't count. You have to hold XXX reserves. And it's similar for the other two of the first three cases. In the fourth case, the reinsurance or affiliated companies is allowed, but the total reserves held by the two companies have to total to the XXX reserve.

Because this is an actuarial guideline, the directives on all of these would be retroactive, which could be a major issue for companies that have sold a lot of insurance using these loopholes. But the regulators who have written this up, for now, have deemed that they should have known better and that it is going to be retroactive. In the case of reinsurance, it's not always clear how the reserve would get split up, even though what it totals to is mandated.

What about shadow accounts? Now that's a little trickier because Regulation XXX does have a rather lenient section that says, if you have a guarantee that is based on a nonlevel pattern of ART-type charges, then the reserve for that is not a XXX reserve; it's a half-c_x-type reserve, based on the valuation mortality in each of those one-year periods.

That means the company could set up a shadow-fund guarantee, which would seem like a way out. For those of you who are unfamiliar, a shadow fund would say, "Okay, here's your base UL policy for life, guaranteed interest rate 4 percent, guaranteed mortality 80 CSO. But for the first 30 years, if you pay premiums such that, based on our current COI scale and, say, a 5.5 percent interest rate, the resulting 'shadow fund' is not zero yet; then you have a guaranteed insurance plan, even if your regular fund value goes to zero."

So, maintaining those non-zero shadow-fund values, given those notional assumptions, would qualify you for a no-lapse guarantee. And the fact is, based on that shadow fund, you can work out a level set of premiums for those 30 years, even though the contract just talks about a nonlevel set of charges.

Now I'm going to editorialize. This seems to be suitable for treatment under the UL model regulation. Remember how we talked about the guaranteed maturity premiums and guaranteed maturity fund? A shadow fund is really kind of a UL within a UL. You've got your basic UL plan that goes forever and has 80 CSO and whatnot, but for 30 years you've got a different plan that has shadow-fund COI charges and a higher interest rate. You could mandate that the company hold reserves based on "guaranteed maturity premiums" that would guarantee, in effect, that the fund would hit exactly zero at the end of the 30 years.

So that's why I say it would be suitable for that treatment. But that's not the way the guideline has gone. The guideline does mandate that you calculate required premiums under the secondary guarantee, the shadow fund. That is the same thing as guaranteed maturity premium treatment. But then those become the specified premiums under XXX and, from then on, you treat it more or less like a segment, with basic and deficiency reserves being calculated based on that new premium pattern.

However, the minimum reserve is the lesser of the single premium for the remainder of the benefit period, or the excess of the actual cumulative premiums, so far, over those required. In other words, if the policyholder has paid a net level

premium into a shadow fund that is higher than product charges for each of the first several durations (i.e., than what would have been required if he was just paying enough to cover the COIs), the excess goes into the reserve.

Well, that gives you some unusual results that have been used to attack AG AXXX by some of the companies that, in fact, have this shadow fund design set up. The first is that the reserve is at least the shadow fund itself—unless this overfunds the remaining benefit; then there is a cap on how high the reserve can get.

What that means is, there's no commissioners reserve valuation method (CRVM) expense allowance on that piece. The shadow fund is greater than zero, but your CRVM expense allowance lets you hold zero in policy year 1 in ordinary UL reserving. AG AXXX would say you still have to hold something higher, even though on the basic UL CRVM piece, there is a CRVM expense allowance. What that means is, you could think of the time to maturity (e.g., to age 100) as a secondary guarantee period, and you get a higher reserve based on AXXX than you do under the normal UL CRVM. This was used as a pretext for throwing the whole thing out. But it looks like the regulators aren't going to buy that, and they're still going to insist on passing it.

Secondly, AXXX is unusual in that this section on shadow funds is largely nonretroactive. Normally, if a guideline interprets a regulation that's been out since 2000, it would say that, for any policies issued under that regulation, it would apply retroactively. But in this case, the writers said it won't apply until after Jan. 1, 2003. So product-development actuaries that are just on the cusp of releasing one of these can still do it; they just have to realize that they may have to do some redesign before 2003.

As for those of you who may be considering other ways to get around XXX, probably none of the ways that are out there are going to work. So we'll have to go back to the drawing board.

On variable life (VL), AG 37 has now been approved by the NAIC. VL, in general, has its own history of regulatory issues. It's generally reserved the same way as the UL counterpart for fixed UL or flexible UL; you've got fixed VL or VUL. The base contract is reserved the same way, but no-lapse guarantees are treated quite differently. The original model regulation has a fixed piece and a flexible piece, and then there's also a revised regulation.

No-lapse guarantees are really important for VL. Since you have a variable contract that can be put into stock, mutual funds, and other things, the fund doesn't even have to go up. Under UL, you have a minimum interest rate of 3-4 percent. On VL, you can't say. The sky's the limit, or the opposite—the depths of the ocean—is the limit for how bad things conceivably could get. So, by providing a no-lapse guarantee, the insurer is providing something quite substantial.

There have been lots of interpretations out there for guaranteed minimum death benefits (GMDBs) on VL. The original regulation had a fixed VL component, which was really for the older policies that tracked the tabular reserve for a fixed policy, but for which you could possibly have fund values and death benefits that would increase if the fund did really well, based on the underlying equities. But you were never allowed to decrease the face below what the face amount originally was on the contract. So you would have a one-year term cost after a one-third drop in the fund, meaning that, if this one-third drop would normally cause your death benefit to go below the face, you'd have to reserve for the difference. That's really kind of meaningless under VUL now.

There's also an attained age level (AAL) reserve piece that requires you to make a calculation of how far short you are if you project your fund values forward under the valuation assumptions. You then determine, if there is a shortfall, where you have to provide insurance on the guaranteed basis, which you would not provide if you didn't have the guarantee.

The AAL works out, if you use valuation assumptions, to be a lot like XXX, for a no-lapse period for VUL. It ends up requiring more or less a humpback reserve, or at least a minimum reserve, based on the projection assumptions. To not have that reserve, you must have premiums that are "sufficient" under the valuation assumptions.

The flexible VL interpretations under the original regulation were not consistent. There were all kinds of views. There was a view that you had to reserve for the entire remainder of the contract, since, if it's flexible, you don't know if you're getting any future premiums or not. That was onerous and too conservative.

There was a view that because the flexible part of the regulation didn't talk about future premiums—but your guarantee required them—there was, in effect, no guarantee, so the reserve is zero. That would be considered superaggressive.

And then there was the in-between view, which would do the same thing as the fixed VL piece; however, unlike for fixed VL, you did have to consider the potential of the one-third drop before projecting values, which was a big problem under heavily funded contracts like single-premium UL.

The revised regulation that was proposed and passed in a few states consolidated this view and specified that any AAL contribution would be made up over the GMDB revenue collection period, not the premium-paying period as before.

That's important because, for single-premium VUL, if you have no future premiums, and if the AAL reserve ever did become an issue, you would have to fund it immediately. Under flexible premium, you could fund it gradually over an annuity factor.

The revised regulation basically said that, if I have some kind of charge that I'll collect for the rest of the policy life, even if it's not premiums (say, a charge of one penny per thousand, coming out of the fund value), then I can assess based on an annuity factor as well.

What does VL GMDB, which is now called AG 37, do? It basically goes with the revised VUL regulation. It says that if you have a fixed-premium requirement on your VUL, you should reserve using fixed-premium VL rules under the original regulation, not the flexible-premium rules, because as far as the no-lapse guarantee is concerned, it is a fixed-premium guarantee.

Remember that the one-year term cost is kind of meaningless for modern VUL, where the face amount would likely never decrease anyway based on fund performance (aside from when in a corridor situation). The AAL piece becomes really important when doing this projection and finding out where your shortfall is.

So this new actuarial guideline adds a bunch of specifications that address areas in the projection that were unclear before. It asserts that you must assume that the GMDB remain in force, if it can (i.e., if the policyholder has that option).

However, if the policyholder's option to extend the guarantee includes the requirement of future premium payments that he may fund at varying points in time, you assume for the projection that he funds them all at the latest legal point that would keep the guarantee in force.

It doesn't mandate that you use any policy charges to make the projection. You just use valuation interest and valuation mortality. It does mandate the use of minimum valuation mortality. It was somewhat unclear before as to whether you could use guaranteed COI—and by doing that, you could lower the charges that you would use for this projection. The new guideline says that you always use the valuation mortality, although it could be select and ultimate as far as we're concerned.

And then it does put an explicit definition on GMDB revenue, defining it to be, not only premiums, but also any GMDB charge, explicit or implicit.

What about using Model XXX select factors or X factors? A lot of VL writers insisted that now you had a nonlevel playing field, because UL writers could get the 80 CSO for basic reserves to be much closer to their experience mortality by using Model XXX select X factors, and VL can't do that. That's not fair.

Unfortunately, that's disallowed by the wording in Regulation XXX, which says that it does not apply to variable products. So that nonlevel playing field under 80 CSO, in fact, does exist.

What's the best bet for VUL? How can we put the pieces of the puzzle together?

First of all, keep premiums nondeficient. Second, to have an initial AAL reserve of zero, you must make those premiums nondeficient. But, then, going forward, the higher you can make them, the more it's going to help, because if the fund performance isn't as good as the valuation interest rate, then you are going to need some help from higher premiums somewhere along the way. And then possibly you'll need to require, as under the revised guidelines in the late '80s, some nonpremium-based GMDB revenue, either an asset-based charge or a per-unit charge.

Let's take a quick look at 2001 CSO. This is really important because it may be given final approval this year. And it affects a lot of what you are going to do as product development actuaries.

If 2001 CSO is approved, state adoption would also begin, and 26 states could adopt by the end of 2003. Statutory reserve implications would vary by different companies, based on their states of domicile. Tax reserves, on the other hand, would be affected within three years of the year after the 26th state adopts. So tax reserve status would not depend on your state of domicile; it would be triggered by this 26th state rule.

And 7702 implications are likely to follow the tax-reserve treatment. I say "likely" because we don't know for sure. We're waiting for an IRS ruling on this. Our tax counsel has said that he thinks that's the way it will go.

How does this affect AXXX and AG 37? Keep in mind, everything I said under those guidelines was based on an assumption of 80 CSO, so it's 80 CSO with model-select factors and X factors under XXX, versus 80 CSO for your AAL reserve projection under AG 37.

For VL, the best hope is your 10-year select factors, which are not that good, compared to the ultimate rates. But if 2001 CSO for statutory purposes is adopted, that would make basic reserve mortality the same for UL and VUL. You'd have a 25-year select-factor table—which is quite good, compared to the ultimate table.

The UL would still have X factors, which would make the total even lower for deficiency reserves, and VL wouldn't be allowed those. But that's not a big concern, because deficiency reserves aren't defined for VL anyway. So they are only a problem for fixed products.

Other product development implications under 2001 CSO include the possibility that you could have some differences in when your company has to adopt for statutory versus tax purposes, and that could cause you to want to hold 80 CSO for tax and 2001 for stat. That may actually work for a couple of years, under certain situations.

You're also going to have different effects on 7702 mortality for protection-oriented

versus accumulation-oriented products. It should help protection-oriented products because it'll make your reserves lower to have this lower mortality basis. But for accumulation-oriented products for 7702, it's going to push your minimum death benefit up, so it actually may be harder to have some of these great products that almost get in the corridor within five or 10 years. And then the insured just lets it accumulate until he decides to withdraw money for retirement (which has been a big way those products have been illustrated and sold).

For traditional products, the implications are generally just lower reserves, and possibly lower cash values as well.

I'll conclude by saying that we've taken a second look, especially at term and UL secondary guarantees, and then at VL or VUL no-lapse guarantees, and the way the guidelines affect those.

Both of these new guidelines are intended to take a second look at how the regulations are making the playing field nonlevel between certain companies or even certain products.

The new mortality standard, 2001 CSO, would affect both of these regulations and have other product development implications that you'll be considering. So the next few years should be quite busy for those in life insurance product development.

Having said that, we will take questions.

MR. PAUL MARGUS: I have a question on AG XYZ. Is it likely that we would also have to revise our policy forms just to specify "see XYZ formula." This, in effect, creates a secondary guarantee, this time on cash values. Does that add to our reserve calculations as well?

MR. VODRAZKA: If you decide to keep your secondary guarantees longer than 20 years, my guess on that is that, yes, you would have to do some sort of filing. My guess is it would require only an informational filing, because you're changing the way that you're setting up your nonforfeiture values, and the higher values are a benefit of the policyholder. Mr. Robbins, if you want to cover the reserve piece?

MR. ROBBINS: I haven't actually given that a lot of thought. Obviously, higher cash values put us at a higher reserve floor. I'm thinking offhand that it wouldn't require a difference in the way you do the CRVM calculation, but I could be wrong.

PANELIST: I'm not an expert on how AG XXX or AXXX affects secondary guarantees, but I would assume that it obviously impacts secondary guarantees requiring a higher reserve. And those are probably already sufficient and would probably not be greatly impacted by AG XYZ.

MR. ROBERT MARKS: I'm with American Fidelity Group, Oklahoma City. I have a

question about the offshore setup, with regard to administration. Are there any minimum requirements in terms of doing the administration offshore as well?

MR. PICHETTE: It's probably largely a tax issue, so I'll take a swing at that one. Assuming you can get offshore and avoid Subpart F, which is the USI Deferral Regime—that would make you pick up the income anyway—the issue then comes down to, do you have a U.S. permanent establishment? Then it's largely a question of how much activity you do in the jurisdiction where you domiciled the offshore company versus what you're doing here. As a practical matter, you want to try to minimize what you're doing in the United States as much as you can.

MR. MARKS: I also have another question on the return of premium as a secondary guarantee, with regard to that on tax reserves. Is it treated as a pure endowment reserve, almost like an unusual cash value in the XXX, when it's almost a pure endowment-type reserve that would be held in addition to the basic reserve? Would that be eligible as a whole tax reserve as well?

The question is on a return-of-premium provision that's in the contract, under an unusual cash-value provision. Under XXX, I believe there is a provision that you must hold a pure endowment-type reserve for that type of a benefit. Would that be a fully deductible reserve as well?

MR. PICHETTE: I'd have to go back and look. Return of premium is a qualified additional benefit. I'm not an expert on this. I've done a little work on unusual cash values. My understanding is that you do have to reserve for it on a statutory basis, but I believe that you cannot take it into consideration when calculating your tax reserves. That's my understanding, but I'm not a tax expert.

MR. MARVIN FINEMAN: I wanted to comment on the issue of letters of credit that was brought up in the offshore reinsurance presentation. At the time that a transaction is set up, it is beneficial to pay attention to the availability and price of letters of credit in the future. It has happened in my career that letters of credit became virtually unavailable at one point. This caused a lot of scrambling. There are ways of getting around it, but it's much better to do it at the outset.

MR. VODRAZKA: And that's why, again, I want to emphasize that direct companies should choose reinsurers wisely. Reinsurers should be well-capitalized; then they should have easier access to letters of credit. There is a big potential impact for reinsurers. Some reinsurers are pricing at the current letter of credit cost, which is pretty low. And, once the humpback reserves kick in and everybody requires tons of letters of credit to be issued, those costs are going to go up, probably drastically. So, again, a well-capitalized reinsurance company should have easier access to that capacity. It doesn't hurt for the company to have other avenues to go down for providing adequate reserve credit if necessary.

MR. MARGUS: I have a question on the 2001 CSO. For UL, it's very customary that

the maximum cost of insurance in the contract can be any table you want, as long as it's the CSO. I know that some states actually say that. But now that we're getting a lower mortality standard, how universal is this requirement? Will it be possible to have contractually guaranteed COIs that are larger than the 2001 CSO?

MR. ROBBINS: I think the consensus among the experts that I've talked to on that is that, in certain states, because of their nonforfeiture requirements, you can't have rates higher than the prevailing mortality table. They're still going to have the same idea after 2001 CSO is passed. There is the possibility that some states might not care, and that you could have different product lines between the two states, though. That's our opinion.

MR. PICHETTE: I expect you'd have a 7702 problem as well, because, for 7702 purposes, you're going to have to use the 2001 CSO. And you'd find yourself upside-down. What you can actually charge or take into account in the 7702 calculation would be less than what you're charging, I suppose.

MR. ROBBINS: Mr. Pichette, did you have anything to add, since I got into 7702 and 2001 CSO, but didn't really get into the tax issues?

MR. PICHETTE: I think the main point on 2001 CSO is that it's going to reduce what premiums you can charge and still meet the 7702 corridors, and that's going to be one of the large pricing consequences of 2001 CSO. It's good from a statutory accounting standpoint, but it's going to limit your pricing because of the tax concerns.

FROM THE FLOOR: I have a question on that. Assuming that 7702 follows the adoption, will there be a three-year deferral on that?

MR. PICHETTE: The three-year deferral is for 807 purposes. There is a provision in 807(d) that says you can elect to defer adoption of a new mortality table for three years after it's adopted by 26 states. I don't think that would apply for 7702 purposes.

MR. ROBBINS: I had said in my session that our retained tax counsel thinks that it will follow the same schedule. But he's not certain by any means, and what we expect is an IRS ruling on the subject.

MR. PICHETTE: It would take some administrative action by the IRS, I think, to get to that answer. Just plain reading in the statute wouldn't get you there.